

# COUNTY MEDICAL SERVICES PROGRAM

## NOTICE OF ACTION

### SPENDDOWN OF PROPERTY

(COUNTY STAMP)

Case number: \_\_\_\_\_

District: \_\_\_\_\_

For: \_\_\_\_\_

(Names)

Your application for CMSP benefits for the month of \_\_\_\_\_ has been reviewed, and it has been determined that you had property in excess of the allowable limit. In order to be eligible for CMSP for the month of \_\_\_\_\_, you must pay \$ \_\_\_\_\_ toward the cost of the medical bills you incurred in the month of application.

The amount you must pay was determined as follows:

Month \_\_\_\_\_

a. Nonexempt property \$ \_\_\_\_\_

b. Property limit – \$ \_\_\_\_\_

c. Excess property \$ \_\_\_\_\_

The amount listed in line c. is \$ \_\_\_\_\_, the amount of medical expenses you must pay. Enclosed is a Record of Health Care Costs (CMSP 177 P) for the month listed. Please follow the instructions on the reverse side of that form. If the medical expenses you pay exceed the spenddown of property amount, and you meet any additional share-of-cost you may have, a CMSP card will be issued to you.

The regulations which require this action are California Administrative Code, Title 17, Section 1498, et seq.

\_\_\_\_\_  
Eligibility Worker\_\_\_\_\_  
Phone\_\_\_\_\_  
Date

**PLEASE READ THE REVERSE SIDE OF THIS NOTICE.**

**APPLICANT COPY**  
**CASE COPY**

**INSTRUCTIONS  
FOR RECORD OF HEALTH CARE COSTS—SPENDDOWN**

*READ THIS CAREFULLY BEFORE CALLING YOUR WORKER.*

1. You had property in excess of the CMSP property limits during the month of \_\_\_\_\_. In order to become eligible for CMSP for this month, you must spend \$\_\_\_\_\_ on medical bills you incurred during this month.
2. Enclosed you will find a form called the “Record of Health Care Costs—Spenddown.” At the top of the form is a box labeled “Spenddown,” which contains a dollar figure of \$\_\_\_\_\_. This is the amount you must pay toward medical care you received during the month listed in number 1 above in order to become eligible for CMSP.
3. Take this form to anyone who gave you medical services, such as a doctor, hospital, or pharmacist, in the month listed above. It is the responsibility of those who gave you services to fill out the form.
4. When the total amount in the “Paid by Patient” column equals exactly \$\_\_\_\_\_, and you have paid that amount, you should then sign the bottom line of the form and return it to your eligibility worker. Please keep the last copy for your own records.
5. Your worker may also have asked you to complete a form called the “Record of Health Care Costs—Share-of-Cost” for the month listed in number 1 above. If you have been given a form, please follow the instructions that came with that form.
6. When you have paid the amount listed in the “Spenddown” space on the form *AND* have paid or agreed to pay the amount listed in the “Share-of-Cost” space on any form(s) you were given, you will be eligible for a CMSP card.
7. If both forms have been completed correctly, you will receive a CMSP card for the month listed in number 1 above.
8. When you receive the CMSP card, it is your responsibility to take the card to the doctors, hospitals, or pharmacists to whom you still owe money. They will use the stickers to bill CMSP for the unpaid part of the bills for the CMSP-covered medical services you received during the month in which you met your “spenddown” and “share-of-cost.”

*PLEASE KEEP THIS FOR FUTURE REFERENCE*